MEDICAL FORMS
for
House of Delegates Page Program

DUE DATE:
FRIDAY, DECEMBER 16, 2022

Please go through each page of the **FOUR** required medical forms carefully. Read the instructions and required information and kindly complete all necessary fields on each form. Before submitting, remember to make a copy of all forms to keep for your records.

Note: A: In lieu of the ***School Entrance Health Form*** supplied in this .PDF file, you may submit a copy of your *current* School Physical Examination Form.

B: Everyone must complete and submit the ***Conditions for Healthcare Services*** and ***Consent to Accompany Minor Patient*** Forms in this .PDF file.

Email ***(preferred)*** a completed set of forms and documents to:

HICS@house.virginia.gov

OR via Postal Service, mail a completed set of forms and documents to:

Virginia House of Delegates Clerk's Office
Attn: Jay Pearson (House Information & Communications Services)
House Page Program
P.O. Box 406
Richmond, VA 23218

QUESTIONS? Please contact:

Jay Pearson
804.698.1524
JPearson@house.virginia.gov

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no earlier than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: ____/____/_____ Sex: _____ State or Country of Birth:_____Main Language Spoken: _____

Student's Address_____ City_____ State_____ Zip Code_____

Name of Parent or Legal Guardian 1:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Name of Parent or Legal Guardian 2:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Emergency Contact:_____Phone:_____-_____-_____Work or Cell: _____-_____-_____

Hospital Preference: _____

Child's Health Insurance: None☐ FAMIS Plus (Medicaid) ☐ FAMIS ☐ Private/Commercial/ Employer Sponsored☐ _____

Box 1. Pre-Existing Conditions

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes: Type 1		
Please list **Life Threatening Allergies**:			Diabetes: Type 2		
			Insulin pump		
Allergies (seasonal)			Head injury, concussion		
Asthma or breathing conditions			Hearing conditions or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart conditions		
Behavioral/Psych/ Social conditions			Lead poisoning		
Developmental conditions			Muscle conditions		
Bladder conditions			Seizures		
Bleeding conditions			Sickle Cell Disease (not trait)		
Bowel conditions			Speech conditions		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental Health conditions			Vision conditions		

Describe any other important health-related information about your child (⊓ Feeding tube , ⊓ Trach , ⊓ Oxygen support, ⊓ Hearing aids, ⊓ Dental appliance, ⊓ Wheelchair, Hospitalizations, etc.):

Box 2. Medications

List all prescription, emergency, over-the-counter, and herbal medications your child takes regularly (Home/ School):

Medication Name	Dosage	Time Administered (Home/School)	Notes
1.			
2.			
3.			
4.			

Additional Medications (Name, Dose, Time Administered, Notes)

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

I_____(do) (do not) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian:_____Date:_____/_____/_____

Signature of Interpreter: _____Date____/____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Part II - Certification of Immunization

Check if the student's Immunization Records are attached using a separate form signed by HCP ☐

Section I

See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box. Please contact your local health department for assistance with foreign vaccine records.

Student Name: **Date of Birth :** / / **Sex:**

Race (Optional): **Ethnicity:** **Hispanic** **Non-Hispanic**

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis Vaccine (DTP, DTaP)	1	2	3	4	5
Diphtheria, Tetanus (DT) or Tdap or Td Vaccine (given after 7 years of age)	1	2	3	4	5
Tdap Vaccine booster	1				
Poliomyelitis Vaccine (IPV, OPV)	1	2	3	4	5
Haemophilus influenzae Type b Vaccine (Hib conjugate) only for children <60 months of age	1	2	3	4	
Rotavirus Vaccine (RV) only for children < 8 months of age	1	2	3		
Pneumococcal Vaccine (PCV conjugate) only for children <60 months of age	1	2	3	4	
Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Measles, Mumps, Rubella Vaccine (MMR vaccine)	1	2			
Measles Vaccine (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
Rubella Vaccine	1	2	Serological Confirmation of Rubella Immunity:		
Mumps Vaccine	1	2	Serological Confirmation of Mumps Immunity:		
Hepatitis B Vaccine (HBV) ☐ Merck adult formulation used	1	2	3	4	
Hepatitis A Vaccine	1	2			
Meningococcal ACWY Vaccine	1	2			
Meningococcal B Vaccine	1	2	3		
Human Papillomavirus Vaccine (HPV)	1	2	3		
Influenza (Yearly)	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

Certification of Immunization

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):** __/__/____

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date. This section must be attached to Part I Health Information (to be filled out and signed by parent).

Student's Name: _____ Date of Birth: |____|____|_____|
Parent or Legal Guardian Name: _____
Parent or Legal Guardian Name: _____
Phone Number: _____

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____

_____

_____

DTP/DTaP/Tdap :[____]; DT/Td:[____]; OPV/IPV:[____]; Hib:[____]; PCV:[____]; RV:[____]; Measles :[____];

Mumps:[____]; Rubella :[____]; VAR:[____]; Men ACWY:[____]; Men B:[____]; Hep A:[____]; HBV:[____]

This contraindication is permanent: [ ], or temporary [ ] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |____|____|____|.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):___/___/___

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on_____.

Signature of Medical Provider or Health Department Official:_____Date (*Mo., Day, Yr.*):|___|___|___|

Section III Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III – COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: ____/____/____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: ____/____/____

Weight:_____lbs. Height:_____ft._____in.

Body Mass Index (BMI):_____BP_____

☐ Age / gender appropriate history completed

☐ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3	
HEENT				Neurological				Skin				
Lungs				Abdomen				Genital				
Heart				Extremities				Urinary				

Tuberculosis Screening

Check the box that applies:

☐ No risk for TB infection identified	☐ No symptoms compatible with active TB disease	☐ Risk for TB infection or symptoms identified

Test for TB Infection: TST IGRA Date:_____ TST Reading____ mm TST/IGRA Result: ☐ Negative ☐ Positive

CXR required if positive test for TB infection or TB symptoms. CXR Date:_____ ☐ Normal ☐ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:

Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

☐ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

☐ Screened by OAE (Otoacoustic Emissions): ☐ Pass ☐ Referred

	1000	2000	4000
R			
L			

☐ Referred to Audiologist/ENT ☐ **Unable to test – needs rescreen**

☐ Permanent Hearing Loss Previously identified: ☐ Left ☐ Right

☐ Hearing aid or another assistive device

Vision Screen

☐ With Corrective Lenses (Check if yes)

Stereopsis ☐ Pass ☐ Fail				☐ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

☐ Pass ☐ Referred to eye doctor ☐ **Unable to test-needs rescreen**

Dental Screen

☐ Problems Identified: Referred for Treatment

☐ No Problem: Referred for prevention

☐ No Referral: Already receiving dental care

☐ **Unable to perform**

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

Summary of Findings (check one):

☐ Well child; no conditions identified of concern to school program activities

☐ Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here):

_____

____**Allergy:** ☐ food:_____ ☐ insect:_____ ☐ medicine:_____ ☐ other:_____

Type of allergic reaction: ☐ *anaphylaxis* ☐ *local reaction* *Response required:* ☐ *none* ☐ *epinephrine auto-injector* ☐ other::_____

____**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

____**Restricted Activity Specify:** :_____

____**Developmental Evaluation** ☐ Has IEP ☐ Further evaluation needed for: _____

____**Medication.** Child takes medicine for specific health condition(s). ☐ Medication must be given and/or available at school.

____**Special Diet Specify:** _____

____**Special Needs Specify:**_____

Other Comments:_____

Health Care Professional's Certification (Write legibly or stamp) ☐ **By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name:_____ **Signature:**_____ **Date:**_____

Practice/Clinic Name: _____ **Address:**_____

Phone:_____-_____-_____ **Fax:**_____-_____-_____ **Email:**_____

MEDICATION ADMINISTRATION GUIDELINES

In striving to maintain a healthy and safe working environment for Pages, the Clerk's Office believes that shared responsibility is best achieved by open communication, mutually understood agreement, and a clear delineation of expectations of what amounts to "routine" administration of medication(s).

It is the responsibility of the House Page Program to ensure that Pages administering medication and/or using medical equipment is done with parental consent and in a safe, consistent manner.

It is the responsibility of the Pages – in coordination with their parents / guardians and healthcare providers – to develop a medication regimen plan, which includes securely storing medications / prescriptions at the Omni Hotel as well as having in-place a responsible practice / regimen of self-administration or usage when appropriate and as prescribed during the duration of the Page program.

Neither Page Program Staff nor Hotel Chaperones will administer, monitor or safeguard medications or treatments prescribed to a Page program participant by a licensed healthcare professional.

- Parents / guardians are expected to develop a medication administration regimen in coordination with a Page's Primary Care Physician when administering routine medication / treatment is a necessary daily requirement for self-management. If applicable, Pages must return the second page of these guidelines to be completed by a healthcare provider and signed by a parent / guardian, if/when appropriate. Completed forms will be kept strictly confidentially on-file with Page Coordinators and Hotel Chaperones.

- There is no registered nurse / healthcare provider readily or immediately available to your child to maintain or administer medications while serving as a Page.

- Parents / guardians will assume responsibility for their Page's medication safekeeping, storage and coordination at the hotel accommodations. It is recommended that parents / guardians supply an appropriate amount of medication for a week's (Sunday evening – Friday afternoon) self-maintenance rather than bringing a full prescription to Richmond.

- It is a Page's responsibility to self-administer daily medications *prior* to leaving the Omni Hotel as prescribed for daily use and in coordination with your primary care physician and parents' acknowledgment / authorization. Medication should not leave the hotel, unless for such condition as diabetes, asthma or allergy as specified in the medication administration form.

- Parents / guardians are required to keep both Page Coordinators and Hotel Chaperones apprised of any changes or additions to the **Medication Administration Approval Form** *(next page)* as changes or modifications are made during the program's duration.

- Pages are **not permitted** to share any prescribed or nonprescribed / over-the-counter medication with a fellow Page or any other on the Capitol Square or at the hotel accommodations ever, at any time. Any known incidents of medication sharing will be dealt with **severely**, with immediate termination from the program. No known incidents of a Page potentially jeopardizing the health and safety of themselves and their peers will be excused.

The House Clerk reserves the right to modify the above stated guidelines and/or implement additional guidelines as necessary.

MEDICATION ADMINISTRATION APPROVAL FORM

To be completed by the Page's Health Care Provider and returned to Page Program Staff:

Completion of this form indicates approval by both a Health Care Provider and Parent / Guardian for a House Page to regularly and/or routinely administer his / her medication as described / prescribed below and has been instructed in its proper use and safe storage.

Page Name: _____

Medication/Treatment: _____

_____

Dosage, Frequency, Route: _____

Diagnosis: _____

_____

Special Instructions, Side Effects, Comments: _____

_____

HealthCare Provider Signature:

_____

Health Care Provider PRINTED Name:

_____

Health Care Provider Address:

_____

Health Care Provider Telephone: _____

Date: _____

Parent / Guardian Signature:

_____

Date: _____

Name:

MR #

(Patient Identification)

VCU Health System
MCV Hospitals and Physicians
Richmond, Virginia 23298

CONDITIONS FOR HEALTHCARE SERVICES

Authorization for Medical Treatment: I authorize and consent to healthcare services including, but not limited to, diagnostic procedures and medical treatment at and by the Medical College of Virginia Hospitals and Clinics (hereinafter collectively referred to as "MCVH") and MCV Physicians (hereinafter "MCVP"). I acknowledge that no guarantees or promises have been made to me as to the result to be obtained from such services.

Teaching Hospital: I understand that MCVH is a teaching hospital and that as such, healthcare services may be provided by qualified individuals in training. I further understand that for teaching and research purposes, patient records may be reviewed by students, trainees, employees and faculty members of MCVH, MCVP and VCU. I also understand that clinical photographs may be taken and that biological materials may be retained following completion of necessary diagnostic and therapeutic procedures. Photographs and biological materials may be used for teaching, study and research purposes and may be published without individually identifying me.

Deemed Consent (HIV/Hepatitis): I understand that if a healthcare provider is exposed to my blood or other body fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV, the virus which causes Acquired Immune Deficiency Syndrome (AIDS)) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider, and that the Virginia Department of Health will be notified and appropriate counseling provided if the results are positive.

Medicare Lifetime Signature Agreement (if applicable): I authorize any holder of medical or other information about me, and their agents, to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request payment under Medicare be made either to me or to the provider, physician or other supplier for services or supplies furnished by the provider, physician, or other supplier.

Financial Agreement: In consideration for healthcare services provided to me by MCVH and/or MCVP for this and all subsequent services, I agree to pay MCVH and MCVP in accordance with their regular rates and terms of payment. I assume full financial responsibility for payment of all charges associated with the healthcare services provided to me including any portion of hospital or physician charges not paid by insurance carriers, workers' compensation or any other third party. Such unpaid charges may include, but are not limited to, deductible and coinsurance amounts and private room charges. Should my account be referred for collection, I agree to pay all collection costs and expenses, including attorneys fees, and I waive homestead and all other exemptions to such debt. I further agree that any lawsuit to collect sums owed by me shall be brought in the City of Richmond.

Assignment of Benefits: In consideration for healthcare services provided to me by MCVH and/or MCVP for this and all subsequent services, I hereby assign to MCVH and MCVP any and all rights, benefits and claims I may have under any policy of insurance (hospitalization, major medical, automobile, liability, workers' compensation, and any other) and the proceeds from any claim that I may have for injuries. Such assignment hereby authorizes direct payment to MCVH and MCVP under and/or from any such policy of insurance or proceeds.

Personal Belongings and Valuables: I acknowledge that I have been instructed to send home personal belongings, valuables and currency, including credit cards. I also acknowledge that I have been informed that MCVH has a safe for small valuables such as jewelry and currency and that it is my responsibility to request use of the safe for such items. I understand that valuables not picked up within 90 days of discharge will be disposed of by MCVH without further liability or responsibility. I also understand that MCVH and MCVP are not responsible for any damage to or theft or loss of dentures, eyeglasses, contact lenses, hearing aids; or any other valuables or personal belongings that I keep in my possession.

Patient Self-Determination Act: I acknowledge that I have been asked whether I have an advance directive such as a living will or healthcare durable power of attorney. I also acknowledge that I have been provided with written information concerning (1) a patient's right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to make advance directives, and (2) MCVH's policy regarding implementation of those rights. Living Will? ☐ Yes ☐ No Healthcare Durable Power of Attorney? ☐ Yes ☐ No

Co-Guarantor: I_____, understand that by signing this document, I agree to accept financial responsibility for healthcare services provided by MCVH and/or MCVP to the patient identified below. If the patient is unable to sign at registration, I accept this "Conditions for Healthcare Services" on behalf of the patient.

I certify that I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions regarding its contents. I understand that this document is valid and remains in effect unless revoked by MCVH or MCVP. I certify I received a notice of privacy practices.

VCU Health System is a Smoke Free Environment

Patient: _____ Date_____ Co-Guarantor: _____ Date_____
Signature Signature

_____ SS#:_____ _____Rel. to Pt.:_____
Print Name Print Name

Witness:_____Date_____ SS#: _____

Unable to Sign at Registration: ☐ Reason:_____

Patient Received Above Information: ☐ Yes ☐ No VCU Representative: _____ _____Date _____
Signature Printed Name

Special Service Indicator:

Consent to Accompany Minor Patient

I, _____, authorize/permit the designated individual(s) listed below to bring my child, _____, to MCV Physicians (MCVP) for medical attention, if necessary, in those instances when I am unable to do so.

I further authorize the performance of procedures deemed necessary by a physician or other licensed independent practitioner, including but not limited to medical treatments and non-invasive procedures, and the administration of medications orally, intravenously, or by injection.

Designated Individuals (Please Print):

Name_____ Relationship to child Chaperone

Name_____ Relationship to child_____

Name_____ Relationship to child_____

Name_____ Relationship to child_____

I understand that all above named individuals will be required to present proper picture identification upon arrival at the MCVP clinic. I further understand that when designated individuals without proper picture identification, and/or individuals not designated in this document to accompany my child, MCVP will not provide general medical treatment (emergent care excluded).

This Consent Form will be maintained in the patient's medical records. Updates to this list of individuals may be furnished by telephone.

_____ _____

Name of Parent or Legal Guardian (Please Print) Date

_____

Last four digits of SS#, mother's maiden name, and/or other identifying information for verbal consent when necessary

_____ _____

Signature of Parent or Legal Guardian Emergency Phone Number

House Clerk's Office

COVID Policies and Procedures*

**These policies and best practices are effective January 1,2023. Further updates and/or changes will be communicated later if necessary and/or as appropriate.*

The Virginia House of Delegates is a busy, active workplace for many employees as well as an appealing destination for daily visitors, especially during legislative sessions. It is the policy of the House of Delegates, under the direction of the Speaker, to take all reasonable precautions to ensure the health and safety of every delegate, full- and part-time employee, page, intern, visitor, and guest of the Virginia House of Delegates while it conducts the people's business.

It is imperative that any Member, staff, lobbyist or visitor in or around Capitol Square who is sick or not feeling well to please refrain from entering the Capitol or Pocahontas Building.

The following plan outlines the practices and policies of the House of Delegates to address COVID-19 during the 2023 Regular Session of the Virginia General Assembly.

The House of Delegates follows COVID guidelines provided by the Virginia Department of Health.

COVID Symptoms:

People with COVID have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. People with these symptoms *may* have COVID:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

House Prevention and Control Practices:

First and foremost, please DO NOT show up if you are sick and/or experiencing COVID symptoms.

The House of Delegates encourages all delegates, staff and visitors to contribute to a safe workplace by being cautious, careful and mindful during their time on Capitol Square:

- All persons in the House are strongly encouraged to get vaccinated against COVID and, if vaccinated, get an available booster to protect yourself, family, colleagues and community.
- Information about COVID-19 vaccine and booster shot availability can be found at vaccines.gov.
- All persons in the House are strongly encouraged to practice good health and safety (e.g., wearing face masks if preferred/needed, hand washing frequently, maintaining social distances as practical and self-monitoring for any illness).

The House Clerk's Office maintains a large supply of KN95 face masks that are widely available at no charge to any who may want or choose to use them for their own health protection and safety when in the Capitol, Pocahontas Building or around Capitol Square. These well-fitting medical-grade face masks offer maximum protection of the respiratory system with up to 95% filtration efficiency as well as balancing breathability and comfort. Disposable nitrile gloves, disinfectant alcohol wipes and hand sanitizer dispensers also are available throughout the buildings, including in committee rooms.

Based on current U.S. Centers for Disease Control and Prevention (CDC) guidelines, face masks are now *optional*. The House Clerk's Office will respect decisions made by individuals.

There are multiple temperature check machines located throughout the Capitol and Pocahontas Building, including near Capitol Police desks at building entrances, to promote self-monitoring for any illness.

Protective plexiglass "sneeze guard" shields remain installed around staff desks in high-traffic areas and hallways in the Pocahontas Building (e.g., administrative assistant desks).

Members of the public, media and lobbyists attending committee or subcommittee meetings in person should not stand in the perimeters of the room or gather in the rear of the room. If a seat is unavailable, meetings can be viewed from the displays outside of committee rooms or via the House live video stream. Seating for bill patrons and presenters invited by the Chair will be reserved in the front row of seating.

For those interested in monitoring House proceedings who cannot secure a seat in the gallery or a room – all House Floor, committee and subcommittee meetings are live streamed and archived at Virginiageneralassembly.gov/hv.

Persons wishing to speak to a bill in committee or subcommittee also have the option to submit written feedback and/or can sign up to speak remotely via HODSpeak.house.virginia.gov. It is the policy of the House that committee and subcommittee chairs endeavor to give equal opportunity to both in person and remote attendees when hearing public testimony.

Additional housekeeping and rigorous cleaning actions again are being implemented throughout the legislative environment to ensure greater safety and health of all as well as decrease the chances of spread of an infectious disease (e.g., all restrooms, common areas that remain in use, doorknobs/handles and other frequently touched surfaces are disinfected daily).

Procedures for Delegates, Legislative Assistants & House Clerk's Office Employees:

Delegates may choose to use plastic shields set on top of their desks in the House Chamber.

Delegates may adopt additional protocols for their individual offices in the Pocahontas Building and can note those in appropriate signage nearby and/or have such communicated to visitors by their assigned administrative assistant.

If persons experience COVID symptoms as outlined above, they should get tested as soon as possible wherever they choose. House employees may obtain an available rapid test kit at House Support Services located on the 7th floor of the Pocahontas Building and/or may seek out testing from a personal health care provider or personal pharmacy.

Test locations in Virginia

If you have been exposed to someone who has tested positive for COVID:

Exposure/Close contact means: Being within 6 feet of a person who has COVID for a total of 15 minutes or more over a 24-hour period.

No quarantine is necessary. However, you should wear a face mask whenever around others for 10 days after your exposure. If you choose to, get tested on Day 6.

If you have tested positive for COVID:

If you have tested positive for COVID and are asymptomatic (not experiencing any symptoms, such as a fever, chills, a cough, or shortness of breath), you should isolate for at least five (5) days.

Day 0 is the day you were tested (not the day you received your positive test result). If you develop symptoms within 10 days of when you were tested, the clock restarts at Day 0 on the day of symptom onset.

If you have symptoms of COVID-19, stay home and isolate for at least 5 days from the date your symptoms began. Day 0 is the day when symptoms started, regardless of when you tested positive.

House Pages:

Although House employees, Pages (13- 14-year old minors), come with special circumstances. Therefore, in addition to the protocols followed by adult employees, House Pages also will adhere to the following:

- Pages who show signs of COVID symptoms will be tested by the Page Coordinators or Page Chaperones with rapid tests.

- If a Page needs to be tested, regardless of the result, parents or guardians will be notified that youth is being tested and then notified of the result.

- If a Page tests positive, he/she will be sent home to quarantine and will adhere to the policy for all House employees outlined above before returning to work.

- It is up to each House Page, and his/her parents/guardians, to decide whether to choose to wear face masks indoors at work, during study hall or in other indoor common spaces.

- Should House Page supervisory staff or a significant number of Pages become ill with COVID, the 2023 Page Program may be suspended either temporarily or for the remainder of Session, to be determined by the Speaker.

Reporting Procedures

Delegates and Legislative Assistants –

In the event of a Delegate's COVID diagnosis:

Delegates should immediately alert the Speaker's Office and the Clerk's Office of the diagnosis.

Members who are isolated because of COVID will have the ability, upon approval by the Speaker, to attend committee and subcommittee meetings as well as floor sessions remotely. When in quarantine due to COVID, members who wish to attend meetings and session on a given day, are required to attend all committee and subcommittee meetings, where they are a member as well as the floor session, or none at all. Members should have their camera on during committee and subcommittee meetings, and active during floor voting.

In the event of a Legislative Assistant's diagnosis:

Legislative Assistants should immediately alert their Delegate and the Clerk's Office of the diagnosis.

House Clerk's Office Support Services staff will contact DGS to provide a thorough cleaning of the Legislative Assistant's and/or Delegate's office if they have been in the space within the last 24 hours.

House Employees –

If an employee is diagnosed with COVID, this information should be reported immediately to that person's supervisor and the Human Resources Director.

House Clerk's Office Support Services will contact DGS to provide a thorough cleaning of the employee's office.

Lobbyists / Visitors / Public –

The House Clerk's Office asks that if a lobbyist, visitor or member of the public in or around Capitol Square is not feeling well, then please refrain from entering the Capitol or Pocahontas Building and take advantage of the online streaming available through the House of Delegates website: https://virginiageneralassembly.gov/house/chamber/chamberstream.php

Plan Implementation:

To ensure awareness of current health and safety guidelines from various health and safety entities, the House Clerk's Office Human Resources Director, Anna Hanback, is responsible for administering this plan, checking for new advisories or information, updating this plan, communicating any changes to employees, and monitoring the overall effectiveness of the plan. She can be reached by telephone at (804) 698-1504 or by email at ahanback@house.virginia.gov.